POLICY MI 5.3 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

A. PURPOSE: To establish guidelines for the use of the Pre-Admission Screening and Resident Review (PASRR) for all persons being admitted to Medicaid registered nursing facilities (NFs).

B. SCOPE: RBHAs and their subcontracted providers.

C. POLICY: Medicaid certified NFs must provide PASRR Level I screening, or verify that screening has been conducted, in order to identify serious mental illness (SMI) and/or mental retardation (MR) prior to initial admission of persons to a NF bed that is Medicaid certified or dually certified for Medicaid/Medicare.

D. REFERENCES: 42 CFR 483.100-138
42 CFR part 447
AHCCCS Medical Policy Manual, Chapter 1200

E. DEFINITIONS:

1. Nursing Facilities (NF):

Nursing facilities provide care for the medically chronically ill and for those recuperating from medical illness who need 24-hour nursing care but not hospitalization. Many nursing facilities offer several levels of care and various specialized services such as therapies.

2. Serious Mental Illness (SMI):

For purposes of this policy, a serious mental illness is defined as a condition of a person whose emotional or behavioral functioning is so impaired as to interfere with his/her capacity to remain in the community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of functional capacities for the primary activities of daily living, homemaking, self-care, employment or recreation. The mental impairment may limit the ability to seek or receive local, state or federal assistance such as housing, medical and dental care, rehabilitation services, income assistance and food stamps or protective services. Although persons with a primary diagnosis of mental retardation frequently have similar problems or limitations, they are not to be included in this definition unless, in addition to mental retardation, they have a separate and distinct qualifying SMI diagnosis.

3. Mental Retardation (MR):

For purposes of this policy, mental retardation is defined as a chronic disability that is

attributable to mental retardation, cerebral palsy or any other related condition. The disability results in the impairment of general intellectual functioning or adaptive behavior and requires treatment or services. The impairment must be manifested before age 22. The impairment must be likely to continue indefinitely and result in substantial functional impairments in major life activities.

4. Specialized Services (pertaining to a Serious Mental Illness):

Specialized services are those services specified by the mental health authority which, when combined with services provided by the NF, result in continuous and aggressive implementation of an individualized plan of care. The plan of care:

a. Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professionals;

b. Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness which necessitates supervision by trained mental health personnel (inpatient/hospital psychiatric treatment), and

c. Is directed toward:

(1) Diagnosing and reducing the person's behavioral symptoms that necessitate institutionalization;

(2) Improving his/her level of independent functioning; and

(3) Achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

F. PROCEDURES:

1. The PASRR screening consists of a two-stage identification and evaluation process and is conducted to assure appropriate placement and treatment for those identified with mental illness and/or mental retardation.

a. PASRR Level I screenings are used to determine whether the person has any diagnosis or other presenting evidence that suggests the potential presence of MR/SMI.

b. PASRR Level II evaluations are used to determine whether the person is indeed MR/SMI. If the person is determined to be MR/SMI, this stage of the evaluation

process determines whether the person requires the level of services in a NF and/or specialized services (inpatient/hospital psychiatric treatment).

2. PASRR Level I screenings

   a. See Attachment A for the PASRR Level I Screening Document and instructions.

   b. PASRR Level I screenings can be performed by the following professionals:

      (1) Arizona Long Term Care System (ALTCS) Pre-Admission Screening (PAS) assessors;

      (2) Hospital discharge planners;

      (3) Nurses;

      (4) Social workers; or

      (5) Other NF staff who have been trained to conduct the Level I PASRR screening and make Level II PASRR referrals.

   c. A PASRR Level I screening is not required for readmission of persons who were hospitalized and are returning to the NF if there has not been a significant change in their mental condition. The PASRR Level I screening form and PASRR Level II evaluation must accompany the readmitted person.

   d. A PASRR Level I screening is required if a person is being admitted to a NF for a convalescent period, or respite care, not to exceed 30 days. If later it is determined that the admission will last longer than 30 days, a new PASRR Level I screening is required. The PASRR Level II evaluation must be done within 40 calendar days of the admission date.

3. Upon completion of a PASRR Level I screening and if necessary, referrals for a PASRR Level II evaluation to determine if a person has a SMI are given to the Arizona Department of Health Services/Division of Behavioral Health (ADHS/DBHS). Referrals for a PASRR Level II evaluation to determine if a person has MR are given to the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD). For dually diagnosed persons (SMI and MR), the referral for a PASRR Level II evaluation is made to both DES/DDD and ADHS/DBHS.

4. When a referral is received by ADHS/DBHS, the PASRR Coordinator reviews it and

consults with the ADHS/DBHS Medical Director, when necessary, to determine if a PASRR Level II evaluation is necessary. If it is determined that a PASRR Level II evaluation should be conducted, the PASRR coordinator must:

a. Forward copies of the PASRR Level I screening and any other documentation to the RBHA; and

b. Send a letter to the person/representative notifying them of the requirement to undergo a Level II PASRR evaluation.

5. RBHAs must develop an administrative process for conducting PASRR Level II evaluations and must ensure that:

   a. They are completed within 7 to 9 working days of receipt of the referral;

   b. If the person is awaiting discharge from a hospital, the evaluation should be completed within 3 working days; and

   c. The criteria used to make the decision about appropriate placement are not affected by the availability of placement alternatives.

6. The PASRR Level II evaluation

   a. The evaluation report must include the components of the PASRR Level II Form (Attachment B).

   b. The evaluation must be adapted to the person's cultural needs.

   c. Current and relevant assessment information obtained prior to the initiation of the PASRR process may be utilized. Findings must correspond to the person's current functioning level and must be descriptive as to how the diagnosis or test scores relate to the person's functional status.

   d. The PASRR Invoice (Attachment C) must be included with the evaluation report.

7. The ADHS/DBHS Medical Director reviews all evaluations and determinations prior to the proposed/current placement.

8. ADHS/DBHS reviews each person when a significant change occurs in the physical or mental condition of those persons determined to have a SMI to ensure the continued appropriateness of nursing home level of care and the provision of appropriate

behavioral health services.

9. ADHS/DBHS must provide copies of the completed PASRR Level II evaluation to the referring agency, AHCCCS, the facility, the primary care provider and the person/representative.

10. Cease process and documentation

    If at any time in the PASRR process it is determined that the person does not have a SMI, or has a principal/primary diagnosis identified as an exemption in the Level I screening, cease the PASRR process of screening and evaluation and document such activity.

11. The ADHS/DBHS Medical Director will determine through comprehensive psychiatric evaluation if the person requires nursing facility level of care and if specialized services are needed in the following circumstances:

    a. The person has been diagnosed with a terminal illness; or

    b. Severe physical illness results in a level of impairment so severe that the person could not benefit from specialized services. The person will be reassessed when notified by the nursing facility of an improvement in their condition.

12. Appeal process specific to PASRR evaluations

    a. The person must be notified of their right to appeal the determination of the PASRR evaluation if they are adversely affected. Appropriate placement recommendations shall be given to the person if they are not determined to need a NF admission.

    b. The RBHA must provide ADHS/DBHS with any requested information in the event that a person appeals the determination of the PASRR evaluation. The RBHA must also provide the ADHS/DBHS with a list of witnesses within 8 days of the request for information and assist in making the witnesses available.

13. Retention

    a. RBHAs must maintain case records for all Level II evaluations for a period of 5 years in accordance with 42 CFR part 447.

    b. RBHAs must permit authorized ADHS/DBHS personnel reasonable access to files containing the reports received and developed.

14. Training

Annual training shall be provided to Psychiatrists and any other medical professionals that conduct Level II evaluations by ADHS/DBHS.

F. APPROVED BY:

Leslie Schwalbe Date
Deputy Director
Arizona Department of Health Services
Division of Behavioral Health Services

Jerry L. Dennis, M.D. Date
Medical Director
Arizona Department of Health Services
Division of Behavioral Health Services

Attachment A

STATE OF ARIZONA
INSTRUCTIONS

PASRR SCREENING DOCUMENT
LEVEL I

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

A. PATIENT INFORMATION

1) NAME: last, first
_____

2) DATE OF BIRTH: _____/_____/_____

3) SOCIAL SECURITY # _____/_____/_____

4) AHCCCS ID #: _____

5) PATIENT COMING FROM?
ADDRESS: street, city, state, zip code, nurses' station

_____

_____

6) Receiving Facility Name: _____

_____

_____
(Include nurses' station)

B. EXEMPTIONS (circle answer)

7) YES NO Primary Diagnosis Dementia? (includes Alzheimer's or related)

8) YES NO Secondary Diagnosis Dementia without primary diagnosis of serious mental illness?

9) YES NO Diagnosis Dementia with mental retardation or related diagnosis and without an SMI diagnosis?

10) YES NO Convalescent care? (admission from hospital after receiving acute inpatient care, requires NF services for same condition and physician has certified before admission to NF that I individual requires 30 days or less NF services).

11) YES NO Respite care? (brief and finite stay up to 30 days per period to provide respite to in-home caregivers to whom individual is expected to return).

C. IDENTIFICATION OF POTENTIAL MENTAL RETARDATION (circle answer)

MENTAL RETARDATION (MR) EVALUATION CRITERIA

12) YES NO Diagnosis of Mental Retardation (MR)?
13) YES NO History of MR/Developmental Disability?
14) YES NO Any presenting evidence to indicate MR?
15) YES NO Referred by agency serving MR clients or eligible for such services?
16) YES NO Individual has any of the following conditions diagnosed prior to 22nd birthday?

- Autism
- Epilepsy
- Seizure Disorder
- Mental Retardation
- Cerebral Palsy
- Developmental Delays (children age 5 and under only)

D. IDENTIFICATION OF POTENTIAL MENTAL ILLNESS (circle answer)

MENTAL ILLNESS (MI) EVALUATION CRITERIA

17) YES NO Primary Diagnosis of serious mental illness (SMI) defined in DSM IV as:

- Major Depression
- Mood Disorder
- Psychotic Disorder
- Schizophrenia (i.e. paranoid)
- Delusional Disorder

and

Level of impairment limiting life activities within the past 3 to 6 months

and

Recent treatment within the past two years?

E. REFERRAL ACTION (circle only one)

18) NO Referral Necessary for any Level II
19) YES Referral for Level II determination for MR only (DES)
20) YES Referral for Level II determination for MI only (DHS)
21) YES Referral for Level II determination for Dual MR/MI

F. Signature of Patient or Representative for a Level II PASRR

I understand that I am required to undergo a Level II evaluation as a condition of admission to or my continued residence in a Title XIX Medicaid Nursing Facility. I also give my permission to disclose all pertinent medical and personal information to any governmental agency involved in this evaluation.

_____ _____
Patient or Patient's Representative Date

G. Signature of Medical Professional Completing Level I PASRR

I understand that this report may be relied upon in the payment of claims that will be from Federal and State Funds, and that any willful falsification, or concealment of a material fact, may be prosecuted under Federal and State Laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete.

In addition, I acknowledge that information supplied in this report may be shared with other state agencies involved in patient screening.

_____ _____
Signature Title

_____ _____/_____
Print Name Telephone Number Date

STATE OF ARIZONA ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

PASRR SCREENING DOCUMENT
INSTRUCTIONS/EXPLANATION

PLEASE PRINT

Initial PASRR Identification and evaluation must take place Prior to Admission to a Medicaid certified nursing facility. If a referral for a Level II is indicated, the patient must not be admitted to a Medicaid certified nursing facility until the Level II portion of the evaluation process has been completed.

A. PATIENT INFORMATION

1. NAME: LAST FIRST
2. DATE OF BIRTH: month, day, year
3. INSERT NINE DIGIT SOCIAL SECURITY NUMBER
4. INSERT AHCCCS ID# (IF APPLICABLE)
5. PT. COMING FROM: (where client is at time of Level I evaluation)
   PRINT: street address, city, state, zip code, nurses' station
6. RECEIVING FACILITY: INSERT NAME

THIS LEVEL I MR/MI IDENTIFICATION PROCESS IS COMPLETE WHENEVER A DECISION IS MADE IN SECTION "E", REFERRAL ACTION.

B. EXEMPTIONS

7. through 11. Please answer these questions based on the patient's current condition and the most recent medical information. IF THE ANSWER TO ANY OF THESE QUESTIONS IS "YES", SKIP SECTIONS C AND D AND GO TO SECTION E "REFERRAL ACTION" AND INDICATE THAT NO REFERRAL FOR LEVEL II DETERMINATION IS NECESSARY.

C. IDENTIFICATION OF POTENTIAL MENTAL RETARDATION (MR)

12. through 16. IF THE ANSWER TO ANY OF THESE QUESTIONS IS "YES", GO TO SECTION E "REFERRAL ACTION" AND INDICATE THAT A REFERRAL FOR A LEVEL II DETERMINATION FOR MR [Department of Economic Security (DES)] IS NECESSARY. Attach any supportive documentation.

D. IDENTIFICATION OF POTENTIAL MENTAL ILLNESS (MI)

17. IF THE ANSWER TO THIS QUESTION IS "YES", GO TO SECTION "E" REFERRAL ACTION" AND INDICATE THAT A REFERRAL FOR A LEVEL II DETERMINATION FOR MI [Department of Health Services (DHS)] IS NECESSARY. Attach any supportive documentation.

E. REFERRAL ACTION

18. through 21. CIRCLE ONLY ONE (1) ANSWER.

F. SIGNATURE OF PATIENT OR REPRESENTATIVE

Read the disclosure to the patient or representative and obtain signature prior to the Level II referral.

G. SIGNATURE OF MEDICAL PROFESSIONAL

Sign and complete the information as requested. Be sure to include a phone number.

Name _____ SS Number _____ DOB _____

Physician's Certification

Location: _____ ____ INT. _____ RRR.

1. Does the patient have a PRINCIPAL diagnosis of dementia? ☐ YES ☐ NO
   If YES, STOP*. If NO, proceed to question 2.
   *DOCUMENT FINDINGS ON NEXT PAGE (HISTORY & EXAM, Page 2)

2. Does the patient have a serious mental illness, according to the criteria of the Arizona SMI checklist? If NO, SEE ABOVE*
   ☐ YES ☐ NO

3. In your professional opinion, based on your psychiatric examination/evaluation of

   _____ performed on _____, does this patient require:
   (Name of Patient) (Date)

a. **Nursing Facility (NF) appropriate**: ☐ YES ☐ NO
   Please Explain Why: _____

   _____

   _____

b. **Specialized Services** (Psychiatric care beyond that available in the current/proposed placement)?
   ☐ YES ☐ NO
   Please Explain Why: _____

   _____

   _____

c. Does this individual require any additional psychiatric care to be provided in this facility? If so, what?

   _____

   _____

_____ BOARD CERTIFIED? _____

Signature/Title ☐ YES ☐ NO Date

ADHS:

I have reviewed the above findings with recommendations that the person has a SMI. ☐ YES ☐ NO

I concur that the person requires a NF level of care. ☐ YES ☐ NO

I concur that the person requires Specialized Services. ☐ YES ☐ NO

COMMENTS: _____

_____

Signature:_____Date:_____Psychiatrist, ADHS Authorized Signer

_____
SS Number

_____
Name

_____
DOB

IDENTIFYING DATA

Examination Date: _____ Time:_____

Age: _____ Sex: _____ Current Marital Status:_____

Ethnic Background: _____ Occupational Background:_____

Level of Education:_____

CHIEF COMPLAINT OR REASON FOR REFERRAL
Pertinent findings from Level I Screening or Annual Resident Review:

HISTORY OF PSYCHIATRIC SYMPTOMATOLOGY

Performed by:_____Date:_____

Title:_____

_____
SS Number

_____
Name

_____
DOB

DEVELOPMENTAL HISTORY:

_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

Include: (1) Childhood illnesses, (2) Significant acute and chronic illness, (3) Surgeries, (4) Injuries and Fractures, (Significant family medical history).

(1)_____

(2)_____

(3)_____

(4)_____

(5)_____

ALLERGIES:_____

DRUG ABUSE
HISTORY:_____
_____

TOBACCO
HISTORY:_____
_____

CURRENT
MEDICATIONS:_____
_____
_____

_____ _____
Performed by Date

_____
Title

_____
SS Number

_____
Name

_____
DOB

Mental Status Examination

(Circle the appropriate answer, circling as many as apply; fill in specific descriptive details. Unchecked or answers that are not circled do not apply or were not tested.)

GENERAL APPEARANCE:

1. Actual age:_____ Apparent age: As stated Older Younger
2. Race/Ethnicity: Caucasian Black Hispanic Oriental American Indian
3. Sex: Male Female
4. Height: tall medium short
5. Build: cachexic thin medium heavy very obese
6. Hygienic state: clean disheveled unshaven odorous
7. Clothing: appropriate untidy peculiar (describe)_____
8. Make-up: Yes No
9. Other:_____

BEHAVIOR/ATTITUDE:

1. Alertness: normal hypervigilant sleepy confused stuporous comatose
2. Posture: slumped normal rigid other_____
3. Gait: normal abnormal
4. Facial expression: unremarkable immobile sad worried angry variable happy other_____
5. Eye contact: good avoided stared into space
6. Attention span: poor satisfactory distractable
7. Motor level: normal hypoactive hyperactive
8. Mannerisms: none posturing echopraxia stereotypy pacing tics handwringing buccolingual-masticator other_____
9. Physiological: none tearful crying blushing sweating tremorous other_____
10. Manner of relating to interviewer:
    a. Warmth: seductive friendly indifferent cold variable other_____
    b. Trust: trustful somewhat trustful mildly suspicious openly distrustful
    c. Gender: appropriate effeminate masculine
    d. Cooperativeness: active cooperation passive cooperation structure-seeking bargaining sarcastic passively uncooperative hostile argumentative vague evasive demanding antagonistic other_____
    e. Style: unremarkable dramatic apathetic worried boastful self-deprecatory other_____
11. Was there a significant change in relating manner during the session? Yes No
    If Yes, describe:

_____
_____
_____

_____
SS Number

_____
Name

_____
DOB
_____

AFFECT AND MOOD

AFFECT: appropriate to content blunted flat inappropriate labile

MOOD: suspicious euphoric shame guilt indifference relaxed
anxious fearful angry depressed agitated other_____

SPEECH:

1. Language: English Spanish Other_____
2. Quantity: mute answers only questions normal verbose
3. Amplitude: soft normal loud screaming monotone
4. Impediments: none stutter lisp slur other_____
5. Speed: slow normal rapid pressured

THOUGHT PROCESSES

ASSOCIATION: tight logical blocking loose incoherent clang (rhyming)

STREAM OF THOUGHT: unremarkable overinclusive concrete echolallic
joking neologistic precise flight of ideas circumstantial
tangential nonspontaneous other_____

CONTENT OF THOUGHT

1. Delusions: Yes (grandiose, persecutory, self-accusatory, somatic) No(e.g.)_____
2. Feelings of Influences: Yes No (e.g.)_____
3. Ideas of Reference: Yes No (e.g.)_____
4. Depression: Yes No (e.g.) _____
5. Obsessions/Compulsions: Yes No (e.g.)_____
6. Phobic Thoughts: Yes No (e.g.)_____
7. Anxieties: Yes No (e.g.)_____
8. Depersonalization/Derealization: Yes No (e.g.)_____

PERCEPTION

1. Illusions: Yes No (e.g.)_____
2. Hallucinations: Yes (auditory visual gustatory olfactory tactile) No (e.g.)_____

_____
SS Number

_____
Name

_____
DOB

SUICIDAL/HOMICIDAL IDEATION

1. Suicidal: Yes No (e.g.)_____

2. Homicidal: Yes No (e.g.)_____

ASSETS (strengths exhibited by patient despite presence of any illness i.e., supportive family, sense of honor, motivation for treatment)

_____

_____

_____

PSYCHIATRIC MEDICATIONS: (list)

_____

_____

DSM IV DIAGNOSIS:

AXIS I: _____

_____

_____

AXIS II: _____

_____

_____

AXIS III: _____

_____

_____

AXIS IV: _____

_____

_____

AXIS V: (GAF Scale) _____

_____

Signature:_____ Title:_____ Date:_____

Attachment B

_____
SS Number

_____
Name

_____
DOB
_____

Mental Status Questionnaire

---

1. Where are we now? _____
2. Where is the place located? _____
3. What is today's date – day of month? _____
4. What month is it? _____
5. What year is it? _____
6. How old are you? _____
7. When is your birthday? _____
8. What year were you born? _____
9. Who is President of the U.S.? _____
10. Who was President before him? _____

(0-2 Absence or mild, 3-5 moderate, 6-8 moderate to severe, 9+ severe)

Number of errors:_____

(1) Digits Forward	(2) Digits Backward
6, 1, 2 _____	2, 5 _____
3, 4, 1, 7_____	2, 7, 4_____
6, 3, 8, 2, 4_____	8, 4, 1, 3_____
9, 7, 2, 4, 6, 3_____	4, 5, 2, 9, 3_____

(3) Serial 7's or Serial 3's: Yes No (4) Three objects: Yes No

INSIGHT:

1. Insight into problem: Yes No (e.g.)_____

JUDGEMENT:

1. Intact: Yes No (e.g.)_____

TARDIVE DYSKINESIA EXAMINATION:☐ negative ☐ positive ☐ Eg._____

Signature/Title: _____ Date:_____

Attachment B

SS Number

Name

DOB

Psychosocial History

1. Evaluation of patient's current living arrangements.

2. Evaluation of patient's current medical and psychiatric support systems.

3. Evaluation of patient's ability to perform activities of daily living and any recent changes in ability to performs ADL's.

Psychosocial History Compiled By

Date

_____
SS Number

_____
Name

_____
DOB

Body Systems and Neurological Screen

REVIEW OF BODY SYSTEMS (Positive Only)

_____
_____
_____
_____
_____
_____

MUSCULO-SKELETAL

ABNORMAL		**NORMAL**
_____	1. Spine	_____
_____	2. Back	_____
_____	3. Joints	_____
_____	4. Upper Extremities	_____
_____	5. Lower Extremities	_____

NEUROLOGIC

ABNORMAL		**NORMAL**
_____	1. Cranial Nerves	_____
_____	2. Finger to Nose	_____
_____	3. Heel to Shin	_____
_____	4. Motor Bulk	_____
_____	5. Motor Strength	_____
_____	6. Motor Tone	_____
_____	7. Reflexes	_____
_____	8. Coordination	_____
_____	9. Movements	_____
_____	10. Sensory	_____
_____	11. Gait	_____
_____	12. Romberg	_____

Signature:_____ Date:_____

PRE-ADMISSION SCREENING
AND RESIDENT
REVIEW INVOICE

CONTRACTOR:_____

CONTRACT NO.:_____

DATE: _____

CLIENT NAME: _____

SOCIAL SECURITY NO.: _____

AHCCCS NO.:_____ ADHS ID NO.:_____

DATE REFERRED:_____ DATE COMPLETED: _____

COUNTY:_____

( ) INITIAL REVIEW ( ) ONGOING REVIEW

LEVEL II EVALUATION PERFORMED BY DR. _____

AMOUNT DUE:$ **300.00**

CONTRACTOR CERTIFICATION

I certify that this report has been examined by me, and to the best of my knowledge and belief, the reported information is valid, based upon our office records and is consistent with the terms of the contract. It is understood that contract payments are calculated by the Arizona Department of Health Services based upon contract terms.

_____

AUTHORIZED SIGNER/TITLE DATE

ADHS CERTIFICATION

( ) Performance Satisfactory for Payment

( ) Performance Unsatisfactory for Payment

( ) No Payment Due

ADHS USE ONLY

PSYCH.TX

__YES

__NO

_____

ADHS AUTHORIZED SIGNATURE / DATE